EXHIBIT 3

Nurse's Notes

Tyler Memorial Hospital

Name: Steven Bennett
Age: 30 yrs **Sex:** Male **DOB:** [redacted]
Arrival Date: 05/12/2017 **Time:** 23:24
Bed Bed4
Diagnosis: Facial contusion and abrasion; Hyperventilation

MRN: [redacted]
Account#: [redacted]
Private MD:

Presentation:

05/12 23:32 Presenting complaint: Patient states: Pt states that he is was struck in face by a PSP, per pt officer Lopez, while at district court . He is complaining of left facial pain in cheek from left cheekbone to left eye socket, pt also saying that he has a headache at this time. — btn

23:32 Method Of Arrival: EMS - Ground: Tunkhannock. — btn

23:32 Acuity: Level 4. — btn

Triage Assessment:

23:40 **Pain:** Complains of pain in left ear, left cheek, left eye and left zygomatic area Pain currently is 5 out of 10 on a pain scale. At worst was 8 out of 10 on a pain scale. Quality of pain is described as throbbing. **Recent Travel History:** No recent travel within the last 21 days. **General:** Appears uncomfortable, Behavior is anxious, crying. The patient was last known well at May 12, 2017 at 23:27. — btn

Historical:

- **Allergies:** No Known Allergies;
- **Home Meds:**
  1. None
- **PMHx:** None
- **PSHx:** nasal surgery
- **Social history:** Smoking status: Patient uses tobacco products, pt states he quit, No barriers to communication noted, The patient speaks fluent English,.
- **Advance directive:** No Full code.

Screening:

23:44 **Suicide Risk Screening:** — btn
Patient Questions: Is the patient presenting with primary complaint of emotional or behavioral disorder or substance abuse? No Do you feel hopeless or helpless: No Have you had thoughts of suicide in the past: No Are you having thoughts of suicide now: No Have you previously attempted suicide: No Do you have a plan to hurt yourself or someone else: No Has a family member or someone else close to you committed suicide or have you been a witness to suicide? No.
Sepsis Protocol:
Patient presentation is not suspicious for sepsis; screening is stopped.

23:44 — btn
Abuse assessment: No assessment findings of abuse, such as: unexplained injuries or bruising, suspicious burns, signs of withdrawal, depression, or fear of others.
Fall Risk:
History of falling in last 3 months: No.
Respiratory/TB Assessment:
TB assessment is negative. Travel History: No. The patient has had close contact or cohabitated with a person who has traveled to a foreign country in the last 10 days? No. Raised poultry or visited poultry farm? No.

Assessment:

23:49 **General:** noted approx 1 inch superficial abrasion to left cheek, contusion noted to left cheek. pt refusing ativan at this time.. **Neuro:** No gross abnormalities. — btn

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
23:42	115 / 82	120	22	99.5	99% on R/A	104.33 kg	5 ft. 11 in. (180.34 cm)	5/10	btn
05/13 00:00	127 / 82	102	18	99.5	96% on R/A			5/10	btn

05/12 Body Mass Index 32.08 (104.33 kg, 180.34 cm) — btn

Print Time: 5/13/2017 14:26:00 ***** CHART COMPLETE *****

Nurse's Notes Con't

23:42

ED Course:

23:29 Patient arrived in ED. btn
23:30 Robert Kraus, MD is Attending Physician. rk
23:45 Arm band placed on left wrist. btn
23:45 Bed in low position. Call light in reach. Side rails up X2. btn
23:46 Noto, Brendan, RN is Primary Nurse. btn
23:46 No provider assisted procedures completed. btn

Administered Medications:

Time	Drug & Dose	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
23:47	Not Given (Patient Refused): Ativan 1 mg IM once							btn

Outcome:

23:53 Discharge ordered by MD. rk
05/13 Discharged to transported by police. btn
00:00 **Discharge Assessment:** Patient awake, alert and oriented x 3. No cognitive and/or functional deficits noted. Patient verbalized understanding of disposition instructions. Patient awake and alert. Oriented to person, place and time. Discharge instructions given to patient, Follow-up phone call after discharge offered Yes.
00:25 Patient left the ED. btn

Signatures:

Robert Kraus, MD MD rk Noto, Brendan, RN RN btn

Corrections:

00:00 ~~05/12 23:32~~ ~~Presenting complaint: Patient states: Pt states that he is was struck in face by an officer while at district court . He is complaining of left facial pain in cheek from left cheekbone to left eye socket, pt also saying that he has a headache at this time.~~ ~~btn~~ btn
05/13 00:00 ~~05/12 23:32~~ ~~Acuity: Level 5~~ ~~btn~~ btn
05/13 00:00 ~~05/12 23:32~~ ~~Acuity: Level 4~~ ~~btn~~ btn
Delete reason: wrong entry
05/13 00:20 ~~05/12 23:45~~ ~~Patient has correct armband on for positive identification. Left wrist. Allergy band applied. "Do not use this extremity" band applied to Bed in low position. Call light in reach. Side rails up X2.~~ ~~btn~~ btn
05/13 00:23 ~~05/12 23:49~~ ~~General: noted abrasion to left cheek, contusion noted to left cheek. pt refusing ativan at this time.~~ ~~btn~~ btn
05/13 00:25 ~~05/12 23:32~~ ~~Presenting complaint: Patient states: Pt states that he is was struck in face by a PSP, per pt officer Lopez while at district court . He is complaining of left facial pain in cheek from left cheekbone to left eye socket, pt also saying that he has a headache at this time.~~ ~~btn~~ btn

Physician Documentation

Tyler Memorial Hospital

Name: Steven Bennett
Age: 30 yrs **Sex:** Male **DOB:** [redacted]
Arrival Date: 05/12/2017 **Time:** 23:24
Bed Bed4
ED Physician Kraus, Robert

MRN: [redacted]
Account#: [redacted]
Private MD:

HPI:

05/13 09:00 This 30 yrs old White Male presents to ED via EMS - Ground with complaints of Facial Injury. rk

09:00 HPI unobtainable due to:. The patient or guardian reports abrasion, crush injury, swelling, tenderness. rk

09:00 Patiaent in police custody in h andcuffed with AOB and very anxious and hyperventilating.. rk

Historical:

- **Allergies:** No Known Allergies;
- **Home Meds:**
  1. None
- **PMHx:** None
- **PSHx:** nasal surgery
- **Social history:** Smoking status: Patient uses tobacco products, pt states he quit, No barriers to communication noted, The patient speaks fluent English,.
- **Advance directive:** No Full code.

ROS:

09:00 rk

Constitutional: Negative for fever, chills, and weight loss.

09:00 All other systems are negative, except as documented in HPI, rk

Exam:

09:00 rk

Head/face: Exam is negative for.

09:00 rk

Constitutional: This is a well developed, well nourished patient who is awake, alert, and in no acute distress.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits.
Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis.
MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.
Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait.
Head/face: Minor tenderness and swelling with small abrasion of left cheek .

09:00 rk

Neck: Exam negative for.

09:00 rk

Neuro: Orientation: is normal.

09:00 rk

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Physician Documentation Con't.

Eyes: Pupils: no acute changes, equal, round, and reactive to light.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
05/12 23:42	115 / 82	120	22	99.5	99% on R/A	104.33 kg	5 ft. 11 in. (180.34 cm)	5/10	btn
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05/12 23:42 Body Mass Index 32.08 (104.33 kg, 180.34 cm) btn

MDM:

23:53 Patient medically screened. rk

05/13 00:52 Financial registration complete. kbj

09:00 rk
Data reviewed: Initial and all vital signs, nurses notes.

09:00 rk
Differential diagnosis; Contusion of.

09:00 rk
ED course: Patient improved before discharge..

Dispensed Medications:

Time	Drug & Dose	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
05/12 23:47	Not Given (Patient Refused): Ativan 1 mg IM once							btn

Disposition:

05/13 09:00 Electronically signed by: Robert Kraus, MD. rk

Disposition:

05/12/17 23:53 Discharged to Home. Impression: Facial contusion and abrasion, Hyperventilation.

- Condition is Good.
- Discharge Instructions: Abrasion, Contusion, Hyperventilation.
- Medication Reconciliation Form form.
- Follow up: Private Physician; When: 1 - 2 days; Reason: If symptoms return.
- Problem is new.
- Symptoms have improved.

Signatures:

Berry, Kathleen, Reg	Reg	kbj	Robert Kraus, MD	MD	rk
Noto, Brendan, RN	RN	btn			

Name: Steven Bennett **MRN:** [redacted]
Account#: [redacted]

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